MDR Tracking Number: M5-04-1371-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 titled Medical Dispute Resolution of a Medical Fee Dispute, and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 1-16-04.

The IRO reviewed supplies/materials, therapeutic exercises, muscle testing, physical performance testing, office visits, range of motion, joint mobilization, myofascial release, therapeutic procedures, and mechanical traction from 3-5-03 to 5-16-03.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. Consequently, the requestor is not owed a refund of the paid IRO fee.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 3-12-04, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$ (Max. Allowable Reimbursement)	Reference	Rationale
3-13-03	97750-MT (2 units)	$86.00	$0.00	G	$43.00 per body area	Rule 133.307 (g)(3) (A-F) 96 MFG Med GR I E 3 & I D 1	Muscle testing is not global to any other service billed on this date. Relevant information supports delivery of service. Recommend reimbursement of $86.00.
3-14-03	99214 95851 97750-MT	$75.00 $40.00 $172.00	$0.00	N G G	$71.00 $36.00 $43.00 per body area	Rule 133.307 (g)(3) (A-F)	Relevant information supports documentation criteria and delivery of service for 99214. ROM and muscle testing are not global to any other service billed on this date. Recommend reimbursement of $71.00 + $36.00 + $43.00 = $150.00.
4-1-03	97750-MT	$172.00	$0.00	G	$43.00 per body area	Rule 133.307 (g)(3)	Muscle testing is not global to any other service

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$ (Max. Allowable Reimbursement)	Reference	Rationale
						(A-F) 96 MFG Med GR I E 3 & I D 1	billed on this date and is reimbursement per body area. Relevant information supports delivery of service to two body areas. Recommend reimbursement of $86.00.
4-17-03	99214 95851	$75.00 $40.00	$0.00	G	$71.00 $36.00	Rule 133.307(g)(3) (A-F)	Office visits and range of motion testing are not global to any other service billed on this date. Relevant information supports delivery of service. Recommend reimbursement of $71 + $36.00 = $107.00
5-16-03	99070 Anti-burst ball 99070 Foam rollers 99070 medicine ball	$48.00 $34.00 $52.50	$0.00	M M M	DOP	Rule 133.307 (g)(3) (A-F) 96 MFG GI III and IV	Carrier denied as "M – fair and reasonable payment"; however, no payment was recommended. These codes require DOP. DOP requirements were not met in that the nature, extent, and need for these codes was not documented and the time required was not documented. No reimbursement recommended.
TOTAL							The requestor is entitled to reimbursement of $429.00.

ORDER

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Order is applicable for dates of service 3-5-03 through 5-16-03 in this dispute.

This Order is hereby issued this 17th day of June 2004.

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division

NOTICE OF INDEPENDENT REVIEW DECISION

Date: March 10, 2004

MDR Tracking #: M5-04-1371-01
IRO Certificate #: 5242

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO).

The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to ___ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a chiropractic physician reviewer who has an ADL certification. The reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

It appears the claimant suffered pelvic, low back and coccyx injury when she fell off a barstool on ___ during the normal course and scope of her employment as a waitress. The claimant was reportedly standing on a barstool and emptying a liquor cabinet when the incident occurred. The next day the claimant woke up in severe pain and was taken by her roommate to a local emergency room where x-rays were taken mainly of the coccyx, sacrum and lumbar spine/pelvic regions. These x-rays were reported as normal for fracture. The claimant presented for chiropractic care on 2/18/03 where her pain levels were reported to be a 9/10 pain level. The second day of chiropractic treatment revealed the claimant's pain levels to be down to a 6/10-pain level. Multiple physical therapy notes and chiropractic notations from 2/18/03 through the designated doctor report of 5/19/03 were reviewed. Several re-evaluations including strength and range of motion evaluations were reviewed. These evaluations occurred on 3/14/03 and 4/17/03. The claimant was returned to work with some restrictions as of 3/17/03 and was returned to work without restrictions as of 4/22/03. The initial chiropractic report revealed there to be no neck problems and all of the findings were solely related to the low back and pelvic region. The daily chiropractic notes revealed the claimant was complaining of various leg pains as well as neck pain; however, the initial emergency room notations revealed the problem to be solely focused in the low back and pelvic region. The claimant was noted to be 5'3" tall and weigh about 130 pounds. The claimant was 34 years of age at the time of the injury. The designated doctor report of 5/19/03 revealed the claimant not to be at MMI; however, she was currently working at ___ at the time of the designated doctor evaluation. The claimant's main complaint as of 5/19/03 was continued sacrococcygeal region pain that reportedly went into the groin area. The designated doctor was not able to review the x-rays which were taken; however, he did recommend that x-rays be taken if they had not already been done. The designated doctor felt the claimant

should see a pain specialist for further evaluation and treatment; however, upon my review of the designated doctor exam findings there would be no clinical basis for this recommendation.

Requested Service(s)

The medical necessity of the outpatient services including TENS supplies and materials, therapeutic exercises, muscle testing, physical performance testing, office visits, range of motion measurements, joint mobilization, myofascial release, therapeutic procedures, and mechanical traction during the dates of 3/5/03 through 5/16/03. I have been asked to not review the physical performance test for medical necessity on 3/14/03 and any and all codes which were billed on 3/14/03. I have also been asked not to review the physical performance evaluation with respect to medical necessity on 4/1/03 as well as the range of motion measurements and physical performance tests of 4/17/03.

Decision

I agree with the insurance carrier and find that the services in dispute were not medically necessary.

Rationale/Basis for Decision

Simply because an injury occurs and extensive rehabilitation services are available, does not make all forms of physical therapy and rehabilitation reasonable and medically necessary. In this particular situation the claimant's injuries were documented to be of the sprain/strain and contusion variety and although significant soreness and pain can result from falling onto one's buttocks or coccyx region, extensive rehabilitation was not warranted or supported by the medical and chiropractic documentation. The chiropractic objective findings in the initial chiropractic exam were minimal and mild. The chiropractic daily notes documented the presence of various trigger points and ropey bands of spasm muscle here and there in the low back. These findings would require a minimal amount of treatment. The initial strength evaluation of 3/14/03 showed that the claimant was capable of working as a waitress. The claimant's pain levels on the first day of active treatment during the disputed date of service of 3/17/03 were only a 3/10 pain level and were a 1/10 pain level in the post treatment setting. The claimant's Oswestry Disability Questionnaire showed her to have a 14% self perceived disability as of 3/17/03, which is very minimal, which was essentially the beginning of the active treatment program as part of the services in dispute. This same pattern continued throughout the rest of the documentation through April 2003. Also, please consider that the claimant missed the next visit of 3/19/03 and when she returned to the clinic on 3/21/03 her pain complaints were documented to be a 0/10 and she demonstrated an 8% Oswestry score, which would reflect that she had very minimal to no complaints. This to me means that the claimant's condition was improving on its own without supervised medical treatment. The claimant's pain level also went from a 9/10 to a 6/10 during a one day period from 2/18/03 to 2/19/03. The documentation suggests that the claimant's pain levels began to decline even prior to the initiation of the more aggressive treatment on 3/17/03. A transition into a home based exercise program with occasional monitoring via office visits would have been reasonable and medically necessary during the disputed dates of service. The objective findings and subjective complaints did not warrant the level of services which were rendered which included up to at least 2 hours of supervised medical treatment. There were improvements in the claimant's overall function from 3/14/03 through 4/17/03; however, these were not significant enough to warrant the extensive treatment rendered and the claimant, again, was noted to be improving on her own without treatment. The designated doctor examination findings were also documented to be extremely minimal. I went over _____ report and there were minimal objective findings to support the recommendation of pain specialist evaluation for further evaluation and treatment. The exam findings did not support at all the need for further treatment. The claimant was given TENS unit supplies on 3/5/03 and these would not be considered reasonable or medically necessary given the nature and type of the injury sustained. Again, the claimant's condition seemed to be rapidly improving on its own without the need for supervised medical treatment or a TENS unit. There is no documentation to support the TENS unit specifically played a role in the claimant's increased function, decreased pain

medication usage or increased overall ability to function. The claimant was prescribed a gym ball or physioball on 5/16/03. The claimant was also given some rollers and a medicine ball on that date as well. While these particular home based exercise modalities and equipment would be considered appropriate in the overall management of low back pain, in this particular situation the claimant responded fine and demonstrated no long term sequelae to substantiate the need for these particular devices. The 4/29/03 date of service demonstrated the claimant to have undergone entirely passive modality treatment which would not be indicated well over 10 weeks post injury especially since the claimant had already been undergoing an active care program and her pain levels were decreasing without the need for medically supervised treatment.